Bridgewater Community Healthcare NHS Foundation Trust

RY2

Other specialist services

Quality Report

Bevan House, Beecham Court, Smithy Brook Road,
Wigan, WN3 6PR
Tel:0800 587 0562
Website:http://www.bridgewater.nhs.uk/

Date of inspection visit: 31 May - 2 June 2016
Date of publication: 06/02/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)

This report describes our judgement of the quality of care provided within this core service by Bridgewater Community Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Bridgewater Community Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Bridgewater Community Healthcare NHS Foundation Trust.

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Requires Improvement

- Community midwives did not have immediate access to basic adult emergency equipment for obstretric emergencies or oxygen for maternal collapse at homebirths. Basic emergency equipment such as a stethoscope, amnihook (tool used to rupture membranes), maternal pocket mask, intravenous fluids, urinary catheters and oxygen were not listed on the home birth check list for the service. This did not assure us that in the event of an emergency, basic emergency procedures would be carried out until an ambulance arrived. There was no evidence of completed risk assessments for homebirth equipment. The Resuscitation Council (UK) 2011 state that staff, in the primary care setting, should have immediate access to appropriate resuscitation equipment such as an adult pocket mask with oxygen port and an oxygen cylinder.
- Community midwives did have a resuscitation "Ambu" bag (a manual, hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately) for babies born in poor condition. However, the homebirth checklist for equipment did not include any other emergency equipment recommended by the Resuscitation Council (UK) 2011, such as a laryngoscope, airways, portable suction and oxygen.
- Emergency skills and drills training, for dealing with obstetric emergencies, were included in the annual mandatory training. However, the homebirth rate was below 1%; therefore, there were significant time gaps for some midwives between home deliveries. Due to the small proportion of women delivering at home, there was no evidence that midwives were provided with resources to maintain skills associated with homebirth practices as well as emergency complications. Staff did not routinely rotate into any of the four local trusts to maintain their skills.
- Policies and procedures were not robust concerning the management of a deteriorating or collapsed patient during a homebirth. Some staff were not aware of some policy pathways such as removing an unwell patient from a pool.
- Some staff, when asked, were not aware where the emergency call bells were located in all the clinical rooms at the Health Care Resource Centre (HCRC).
- There was no emergency call bells in the clinical area cubicles used at Halton hospital. These clinical areas did not have piped or portable oxygen or suction in the rooms or cubicles, in the event of an emergency.
- Emergency resuscitation trolleys were shared with other health services at both HCRC and Halton hospital sites and were stored out of the maternity areas in both sites. Staff informed us that they were not involved with the daily checking of the emergency equipment and were not aware what the equipment consisted of.
- There was no evidence seen that clinical audit systems and processes were established to continuously assess, monitor and improve the quality and safety of services provided.
- Staff reported that they were aware how to report incidents; these incidents were reviewed and investigated locally by the HOM and risk management midwife. However, there was no evidence provided that feedback from lessons learnt improved service needs or the quality of experience for patients.
- The maternity risk register was up to date however; there was discrepancy between staff about what was on the register and what action plans were being implemented to improve practice.
- The record keeping system involved the use of digital pens (a battery-operated writing instrument that allows the user to digitally record patient information in the handwritten notes). However, use of the digital pens were on the risk register as they did not consistently or effectively collect and store accurate and up-to-date information about patients. Therefore, this did not reassure us that records and information were accurate, complete or contemporaneous. However, there were plans for the service to implement a new IT system using ipads.

Summary of findings

- The trust did employ a young parent's midwife, who provided support to patients less than 19 years. However, the trust did not employ a specific specialist bereavement midwife, mental health midwife or safeguarding midwife however, there was evidence of good multidisciplinary working with the safeguarding nurse team. The Head of Midwifery (HOM) was the named safeguarding link midwife.
- Some midwives were not aware of the trust values or plans for the further of the service.
- Staff informed us that some patients had been involved in the design of the trust maternity hand held notes and pop up information posters that were displayed in the clinical waiting areas.
- There were four supervisors of midwives (SOM), including the Head of Midwifery. This met best practice Birthrate Plus recommendations 2007.
- Clinical areas were clean and tidy and were well sign posted for patients to access.
- The number of midwives employed met best practice Birthrate Plus recommendations 2007. The service had systems in place between team leaders to review midwifery staffing levels regularly.
- At the time of inspection, all staff had completed their annual appraisal review.
- Multiagency and disciplinary working was established and promoted the best outcome for mothers and their babies.
- Patients, we spoke to and observed, were cared for with kindness and compassion and they were positive about the standard of care and treatment provided by the maternity services.
- Staff, we spoke to, informed us that the community teams were managed well by the team leaders and that staff were well supported by the supervisors of midwives.
- During our unannounced visit, management had responded well to some risks, which had been identified and escalated during our announced visit. This included an action plan to review staff competencies, emergency equipment at homebirths and auditing of information

Summary of findings

Background to the service

Information about the service

The Bridgewater community midwifery service offers pregnant patients antenatal, home birth, and postnatal care living in the Halton area. Halton consists of a wide geographical area, including two towns, Runcorn and Widnes.

Two community midwifery teams provide care in this area. In addition, patients are required to also book at a local hospital to process their blood tests, access specialist services and obstetric input if required. These local trusts include St Helens & Knowsley Teaching Hospitals NHS Trust, Warrington & Halton NHS Foundation Trust, Liverpool Women's Hospital NHS Foundation Trust and the Countess of Chester Hospital. Community midwives also offer a home birth and pool birth services.

Community midwifery services provide care at different venues including health centres, GP surgeries, Halton hospital and home visits. Three trust consultant led clinics were available in the community setting.

Obstetric ultrasound scans were performed at the Health Care Resource Centre (HCRC) Widnes, and at the patients chosen hospital.

The overall caseload of the community midwifery service was approximately 1600 patients annually, equally split between the two teams. The whole team consisted of a Head of Midwifery, twenty-five community midwives, one midwifery support worker and part time administration and clerical staff.

We visited the maternity service during the announced inspection between 31 May and 2 June 2016 and the unannounced inspection 16 June 2016. During our visits, we spoke with 23 staff, two student midwives, one consultant and two patients. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for six patients. We attended one teaching session provided by midwives. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Our inspection team

Our inspection team was led by:

Wendy Dixon: Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a midwife,nurses and therapists

Why we carried out this inspection

We carried out a comprehensive inspection of this service as part of a routine programme of inspections and to rate the service.

How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of findings

Before visiting, we reviewed a range of information we hold about the core service, performance information received from the trust and asked other organisations to share what they knew.

We carried out an announced visit from 31 May 2016 to 2 June 2016 and an unannounced visit on the 16 June 2016.

As part of the visit we held focus groups with a range of staff who worked within the service, such as midwifes, nurses, doctors and therapists. We observed how care and treatment was provided.

What people who use the provider say

- There was no Maternity Services Liaison Committee (MSLC). The MSLC acts as a multi-disciplinary forum, bringing together the different professions involved in maternity care and user representatives to discuss national strategies and how these could be implemented to improve care. This did not assure us that services were designed and improvements made that met the needs of local patients and their families.
- The Service did not carry out any recent home birth user satisfaction survey or audit. However, patient focus groups were held for the LSA audit visit in 2015. Staff informed us that some home birth mothers attended to give their feedback but were unable to tell us how many attended.
- The Friends and Family Test (FFT) showed between January and March 2016, 16 patients completed the antenatal responses. 100% reported they would recommend the service. There were 63 postnatal responses; between 95% and 100% reported, they would recommend the service. Bridgewater had set a threshold of 95%, therefore achieving this target.
- 434 annual service feedback questionnaires were returned in 2015. 227 responses from the Runcorn area and 206 for the Widnes area. 433 answered yes to the service meeting their needs and that information was delivered in a professional style. The majority of responses reported having continuity of care, had a chance to ask questions and received a satisfactory answer. The majority would recommend the service to friends and family.
- Annual patient service feedback questionnaires 2016 were distributed over a one-month period and were in progress at the time of inspection.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust MUST take to improve

- The provider must ensure that staff have the necessary competencies, knowledge, skills and experience in order to deliver care and treatment safely during a home birth**.**
- The provider must ensure routine or mandatory trust rotation into the local acute trusts, to keep staff updated with skill aptitude and proficiency.
- The provider must ensure regular training for pool deliveries to ensure staff competencies and trust policies are followed correctly.
- The provider must ensure that basic emergency and resusitation equipment are immediately available for their home birth service.
- The provider must ensure staff training for any new emergency equipment purchased.
- The provider must ensure a more robust audit system to assess trends, implement lessons learnt and improve practice and services.
- The provider must ensure the development of robust action plans and methods of implementing audit findings.
- The provider must ensure how risks and incidents are assessed and managed and provide a robust feedback system to staff.

Summary of findings

- The provider must ensure easy accessibility and storage location of resuscitation trolleys at the HCRC and the Runcorn clinics and that all midwives take responsibility for daily checks to ensure staff competency in using the resuscitation equipment.
- The provider must ensure the safe and effective use of patient data collection using digital pens.
- The provider must ensure improving the emergency nurse call bell system at the HCRC.
- The provider must ensure establishing a Maternity Services Liaison Committee (MSLC), to enable maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families.

Action the trust SHOULD take to improve

- The provider should consider how the information on the maternity dashboard could be used to inform and improve practice.
- The provider should consider methods to increase the home birth rate.
- The provider should consider offering pethidine or another opioid as a form of pain relief at home births.
- The provider should consider completing a risk assessment for the use of syntometrine, as syntocinon is recommended by NICE.
- The provider should consider consistent and regular staff attendance at trust mortality and morbidity meetings and local and trust wide governance meetings to learn lessons from other incidents.
- The provider should consider the privacy and dignity of patients at the maternity facility at Haltom hospital, as curtains are used in the cubicles.
- The provider should consider the impact on the maternity service in line with changes in legislation removing the statutory elements of supervision and the disappearance of the supervisor of midwives posts.

Bridgewater Community Healthcare NHS Foundation Trust

Other specialist services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Community midwives did not have immediate access to basic adult emergency equipment for obstretric emergencies or oxygen for maternal collapse at homebirths. Basic emergency equipment such as a stethoscope, amnihook (tool used to rupture membranes), maternal pocket mask, intravenous fluids, urinary catheters and oxygen were not listed on the homebirth check list for the service. Staff also informed us that they did not carry this equipment with them for homebirths. This did not assure us that in the event of an emergency, basic procedures would be carried out until an ambulance arrived. There was no evidence of completed risk assessments for homebirth equipment. The Resuscitation Council (UK) 2011 state that staff, in the primary care setting, should have immediate access to appropriate resuscitation equipment such as an adult pocket mask with oxygen port and an oxygen cylinder.
- Community midwives did have a resuscitation "Ambu" bag (a manual, hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately) for babies born in poor condition. However, the homebirth checklist for equipment did not include any other emergency equipment recommended by the Resuscitation Council (UK) 2011, such as a laryngoscope, airways, portable suction and oxygen.
- Assessing, mitigating and managing risk was poor by staff. Anticipation and processes of events going wrong or the event of an emergency was poor. At the time of inspection, staff told us they only booked low risk patients so did not envisage poor outcomes or high-risk emergencies. If something did go wrong, they told us they were happy to call for an ambulance or an emergency crash team and wait for help to come. This did not provide reassurance that staff assessed, prevented, detected or anticipated risk to ensure the health and safety of their service users.
- Facilities and environments we visited were clean, tidy and appropriately located for their purpose. However, in the maternity area at Halton Hospital, curtains were used in the three cubicles provided for maternity services. We observed that clinical conversations between clinicians and patients could be heard between the cubicles.

Requires improvement

Are services safe?

- In the maternity clinical area at Halton Hospital, there were no emergency call bells, no oxygen or suction equipment. Emergency equipment for general use was stored in a locked cupboard by the hospital main entrance, which was a distance from the maternity area. This did not reassure us that patient safety in an emergency was assessed for risk or timely treatment was provided to service users.
- At the HCRC, there was only one emergency resuscitation trolley within the whole building. This was not situated or located near the maternity area. Staff were not aware where it was stored or what equipment the trolley contained. Again, this did not reassure us that patient safety and timely treatment in an emergency was assessed for risk or provided to service users.
- Staff reported that they were aware how to report incidents; these incidents were reviewed and investigated locally by the HOM and risk management midwife. However, there was no evidence provided that feedback from lessons learnt improved service needs or the quality of experience for patients.
- Digital pens used to collect and store patient data was troublesome and at times ineffective. However, the trust was exploring new data collection systems. Staff reported that data was often not stored on the system when they entered patient information and a lot of time was spent ringing the production company helpline for advice and support. This did not reassure us that care and treatment was recorded and stored accurately and contemporaneously.

However:

- The number of midwives employed met best practice Birthrate Plus recommendations 2007. The trust had systems in place between team leaders to review midwifery staffing levels regularly. High staff sickness did affect the service between December 2015 and April 2016 but this was resolved by the time of inspection.
- Processes including methods for alerting staff to ongoing patient concerns and multi-agency working were good.
- We observed that clinical and staff areas were clean and tidy. Leaflets and notice boards were visible to patients.
- Staff informed us that the Entonox (gas and air) cylinders for home deliveries were delivered directly to patient's home by the trust transport service. Therefore, the staff did not have to carry these cylinders in their cars.
- An external agent collected dirty clinical waste following a homebirth directly from the patient's home. This avoided midwives carrying dirty clinical waste in their cars.
- Information provided by the trust confirmed that all midwives had completed safeguarding level 3 training.
- The trust responded promptly to actions identified during the inspection. An action plan was under way at the time of our unannounced visit to review emergency equipment, supervisor of midwives role in the future, up to date skills of midwives and robust auditing processes.

Incidents

- Reported incidents received from the trust showed that between January 2015 and December 2015, there were 226 maternity incidents recorded. Of these, there were 104 records management incidents, 47 fetal and neonatal incidents and 14 communication incidents reported.
- The trust trend analysis report from April 2015 to March 2016, showed 239 reported incidents and 99 near misses. The top incidents reported included: records management, readmission of mum or baby within 30 days of discharge, communication, antenatal scans and screening not actioned appropriately.
- Records management was the most reported incident due to the introduction of the digital pens to record clinical data. This had been entered onto the corporate risk register. Staff reported that data collected using the pens was often not stored on the system when they entered patient information and a lot of time was spent ringing the production company helpline for advice and support.
- Staff told us they were encouraged to report incidents regularly and were aware how to do so. Information received from the trust showed that a guide was available to staff in the form of a "trigger list" for staff to follow when deciding what incidents needed reporting.
- Four midwifery staff had received root cause analysis training and these staff were involved in the root cause analysis (RCA) investigations following reported incidents.
- The system for managing the progress of incident investigations and follow up were the responsibility of the risk management midwife and the Head of Midwifery (HOM). Feedback to staff was provided at the six weekly joint team meeting or on an individual basis.

Requires improvement

Are services safe?

- If investigations involved poor professional practice, a Supervisor of Midwives (SOM) would be involved with the investigation and feedback was on a one to one basis with the individual member of staff.
- Incident report review meetings were held to discuss lessons learnt and action outcomes of the review but staff informed us that these meetings were not held regularly. However, when these meetings were held, records we reviewed confirmed that staff attendances at these meetings were poor. Five staff attended in July 2015, four staff attended in November 2015, one midwife and one student midwife attended in March 2016. The April meeting was cancelled. Outcomes from the individual reviews contained suggestions and considerations but there was no evidence of timelines for completion for these suggestions, no allocated staff members to lead the proposed work or no review dates documented.
- Some staff told us that lessons learnt were received by email, documented in the communication diary, available on the risk management notice board, written in the risk management newsletter (published twice a year) and by word of mouth.
- Some staff informed us that some lessons learnt from other local trusts were shared with staff at the six weekly joint team meeting by the HOM. There were also lessons learnt available on the trust intranet hub from other services within the trust such as the district nursing team that the staff could read.
- However, some staff we spoke to, were unable to give us examples or evidence of immediate changes implemented into practice that were a direct result from lessons learnt. Lessons learnt were not displayed in any of the maternity areas we visited during our inspection.

- Bridgewater community midwifery service was subject to an external quality assurance visit November 2015 by the Public Health England Screening Quality Assurance Service (PHE SQAS). The visit was specific to antenatal and newborn screening programmes. A number of issues were identified during the review and suggested actions were provided by the PHE SQAS. Staff informed us that the local PHE Screening and Immunisation team had supported the midwifery team in developing and implementing the 28 recommendations (3 immediate, 11 high, 13 medium and 1 low) within the recommended timescale of between 7 days to 12 months depending on severity of recommendation. At the time of our inspection, 12 of these recommendations had been completed.

- Since the PHE SQAS visit, a full time screening midwife post was created. Staff reported that the improvements and changes in practice was the “most positive thing that has happened in the trust” and that they had received great support from senior management and executive board. Staff felt that it has put “screening on the map” as it had gone “unnoticed for so long”.
- Following the PHE SQAS visit, a fail safe Fetal Anomaly Screening Programme (FASP) programme and new guideline was put into place immediately in order to prevent any women missing their screening tests in the first and second trimesters.
- Examples of new FASP programme included; the sonography department faxed copies of all scans to the screening midwife on a daily basis for Bridgewater patients. This allowed the screening midwife to contact patients directly for blood testing and make appointments as necessary. The patients were then contacted approximately one week later to ensure they had a result. The screening midwife kept a paper record and the results were entered onto System One computer system. All failed Nuchal translucency (NT) scans and patients who did not attend scan appointment, were documented and followed up by the screening midwife. This provided assurance that all systems and processes were established and operated effectively to ensure all patients were screened according to policy.
- The trust had also installed a new computer system to allow the staff to order blood tests electronically and therefore have reliable data. A Clinical Record Interactive Search (CRIS)computer system had also been installed to allow the screening midwife to view daily scanning lists and reports for patients who were recently scanned. Again, this provided assurance that all systems and processes were established and operated effectively to ensure patients did not miss any screening requirements.
- The trust had recently set up a Bridgewater antenatal screening meeting as well as the screening midwife attending other local trust screening and laboratory meetings.

Requires improvement

Are services safe?

- Staff reported that patient mortality and morbidity information was recorded by the individual trusts patients were booked at, not by the community midwifery service. Staff reported that they would be invited to attend mortality and morbidly meetings if it was related to any of the patients that they have provided care for. Staff informed us that this did not occur very often. Staff were aware of their responsibilities relating to Duty of Candour legislation and senior staff were able to give us examples of when this had been implemented. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Senior management team reviewed the maternity services business continuity plan annually, reviewing the impact of major disruptions to the service due to loss of staff, loss of workspace, loss of information technology (IT), loss of equipment and/or loss of supplies.

Safeguarding

- There was no specific safeguarding midwife role. The HOM incorporated the safeguarding role within her job. This included being informed about court requests, baby deaths, and attending the Bridgewater safeguarding meeting from a strategic role.
- Staff told us they felt confident completing the appropriate safeguarding documents and making referrals to the safeguarding team.
- Midwives attended individual patient case conferences when it involved patients in their caseload. This gave assurances of continuity of care and that safeguarding issues were communicated directly through multidisciplinary working partnerships.
- Staff informed us that they kept the HOM updated verbally with any safeguarding issues.
- Staff told us that there were monthly safeguarding supervision meetings, chaired by one of the senior midwives but the meetings were sometimes cancelled due to clinical work demands and sickness. If this occurred, issues were addressed on a one to one staff basis or discussed at the following months meeting.
- Staff informed us that they had a good working relationship with the safeguarding specialist nurse teams, who were supportive and helpful to the midwifery teams. During our inspection, we were introduced to the safeguarding team as they shared the same office building as one of the midwifery teams.
- We reviewed a document called "Information sharing/ Cause for Concern Form" which was an extra communication tool between the midwifery teams and the mental health team, safeguarding nurses, other midwives in the trusts and the four local trusts. Health visitors and GPs were also copied into this correspondence. Staff told us that these information forms were emailed to the different services by a secure NHS email account and by internal post.
- Staff told us that Common Assessment Framework (CAF) forms were completed for parents with specific needs. CAF is a standardised approach to assessing a child's additional needs and decides how those needs should be met. Practitioners can use it across all children's services. (Every Child Matters: Change for Children Programme 2004).
- Minutes were provided from the Safeguarding, Supervision and Practice Reflection meetings from November 2015 and May 2016. Six staff attended the November 2016 meeting. The action plan column was not completed and the action plan sheet blank. Five staff attended the May 2016 meeting. The action plan log was completed but no timeline for actions were documented.

Medicines

- Two Entonox (gas and air) cylinders for home deliveries were delivered directly to patient's home at 36 weeks of pregnancy by the trust transport service. This service meant that community midwives did not have to carry the cylinders of gas in their cars.
- Staff administrated an intramuscular drug called syntometrine to help deliver the placenta. NICE (2004) recommend syntocinon rather than syntometrine to be used, as it is less likely to cause nausea, vomiting and transient high blood pressure. Staff said they used syntometrine as it was cheaper and it could be stored out of the fridge for two months. Unused or out of date syntometrine was disposed in a sharps bin by midwives. Senior midwives told us that the trust was looking into changing to syntocinon but were told that it had financial implications for the service.

Requires improvement

Are services safe?

- Drugs were stored in a room with a keypad entry at HCRC. The cupboard and fridge were locked and the administration staff completed daily temperature checking.
- At the time of inspection, we found the drugs fridge contained out of date flu vaccinations. Staff informed us that the last flu vaccine clinic for their pregnant patients was February 2016 and the unused vaccines needed to be returned to main pharmacy.
- Anti D injections (given to patients whose blood group is RhD negative) were delivered in a cool box from pharmacy and were stored immediately by staff.
- When restocking or reordering drugs, it was the role of a senior staff member to complete a new drugs order form and bring this and the empty drug boxes from HCRC to the pharmacy department at Halton Hospital. Drugs were returned within a couple of days by a courier, in a secure pharmacy delivery box. A checklist was completed on arrival at HCRC and returned to pharmacy. There was an up to date signing in and out record book.
- Drugs that were required from Warrington hospital were ordered from a set order list, which was faxed to Warrington Hospital pharmacy. This was also returned to HCRC by secure courier and sign in for by staff.
- Pethidine was not offered as a form of pain relief at home births. NICE (2007) state that pethidine, diamorphine or other opioids should be available in all birth settings. There was no pain relief risk assessment completed by the service. Staff told us, if homebirth patients required other pain relief, apart from gas and air, they would need transferring to a local trust.

Environment and equipment

- Community midwives did not have immediate access to basic adult emergency equipment for obstretric emergencies or oxygen for maternal collapse at homebirths. Basic emergency equipment such as a stethoscope, amnihook (tool used to rupture membranes), maternal pocket mask, intravenous fluids, urinary catheters and oxygen were not listed on the home birth check list for the service. This did not assure us that in the event of an emergency, basic emergency procedures would be carried out until an ambulance arrived. There was no evidence of completed risk assessments for homebirth equipment. The Resuscitation Council (UK) 2011 state that staff, in the primary care setting, should have immediate access to appropriate resuscitation equipment such as an adult pocket mask with oxygen port and an oxygen cylinder.
- Community midwives did have a resuscitation "Ambu" bag (a manual, hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately) for babies born in poor condition. However, the homebirth checklist for equipment did not include any other emergency equipment recommended by the Resuscitation Council (UK) 2011, such as a laryngoscope, airways, portable suction and oxygen.
- The trust's 'Planned Home Birth' policy lists reasons for transfer into hospital and advises to summons an ambulance by dialling 999. Staff told us that the lack of basic maternal resuscitation equipment did worry them. Other staff told us, that they had been asking for emergency equipment for years but their request and concerns were ignored. At the unannounced visit, staff informed us that they were completing a scoping exercise across the maternity units in the Cheshire and Mersey area and beyond to benchmark and upgrade their emergency equipment.
- Staff informed us that they did have access to a baby resuscitation bag and mask, if a baby was born in a poor condition at a homebirth. The resuscitation council (2011) states that resuscitation may be started with air. However, where possible, additional oxygen should be available if there is not a rapid improvement in the infant's condition. Currently, the service did not carry any oxygen.
- Staff informed us that at the midwifery annual skills and drills training day, the neonatal training team, questioned them about not having more robust baby resuscitation equipment available. Some midwifery staff told us that, they did not follow this up with management; other staff said they had highlighted this with management but were ignored. One staff member informed us that the training facilitator had emailed management directly herself but she did not receive a reply. Staff felt that the lack of basic emergency equipment was due to the cost implications and the

lack of funding. This did not assure us that the trust was fully able to support the competency of their staff and provide basic resuscitation care when required (Safer childbirth, RCOG 2007).

- During the inspection, we found that there were no homebirth equipment risk assessments on the impact of not carrying oxygen or other emergency equipment completed. We raised this with the trust at the time.
- Following our inspection, staff completed a risk assessment for safe care of a woman and baby delivering at home in the absence of oxygen and neonatal suction. The consequence and likelihood of a potential hazardous or adverse outcome scored "moderate". The likelihood of the event occurring was scored "rare".
- During the unannounced phase of the inspection, staff informed us that the trust had decided to suspend their homebirth service while the trust had completed a scoping exercise across the maternity units in Cheshire and Mersey and beyond to benchmark and upgrade their emergency equipment.
- Senior midwives also informed us on the unannounced inspection, that the trust were sourcing and possibly purchasing oxygen cylinders, which would be delivered with Entonox cylinders directly to the home of the patient planning a home birth. This was in line with trust regulations for the safe transport of medical gases.
- On the unannounced inspection, midwives informed us that the trust was also planning to purchase emergency 'grab' bags, containing equipment such as a urinary catheter, intravenous fluids for cord prolapse and suction tubes. The plan was for the on call homebirth midwife to check and collect this bag every day, in case it is required at a home birth.
- On the unannounced visit, staff also informed us that the trust had ordered emergency adult resuscitation bag and masks. Staff told us that in future, adult basic life support would be part of the midwives bespoke annual skills and drills training day.
- The HOM informed us that once the emergency equipment was purchased and staff training was completed, a Standard Operating Procedure (SOP) and appendices would be added to the home birth policy and submitted for ratification to the trust policy assurance group in July 2016. The HOM was hopeful that the homebirth service could restart following this. This gave us assurance that the service was investigating systems, processes and necessary equipment to ensure the safety of service users and to meets their needs.
- Staff informed us that training for any new additional equipment would be provided and recorded with a plan for updates as necessary.
- When we asked staff about the process for an emergency evacuation of a patient from the birthing pool, some staff were unable to inform us correctly. We highlighted what the trust policy stated to staff. This did not assure us that staff were competent and trained in pool deliveries.
- Staff also informed us the emergency evacuation nets for pool deliveries were available and stored "somewhere" in the office bases but were unsure where exactly. Again, this provided no assurance that patient safety and staff training was adequate.
- There were emergency call bells in each clinical room at the HCRC however, not all staff were aware of them when asked.
- There was only one shared emergency resuscitation trolley in the HCRC and this was stored in the Urgent Care Unit, across the main reception waiting area. Midwifery staff told us that they did not routinely check or had ever used the shared resuscitation trolley. There was not a dedicated trolley in the maternity clinical area. This meant that in the event of a collapsed patient or relative, staff would verbally shout for help and wait for help to come.
- Midwives informed us that the resuscitation trolleys at HCRC and the Runcorn clinic were not owned by the midwifery service therefore, the midwives did not take responsibility for daily checks or stocking the trolley with equipment. This meant that we were not assured about patient safety and staff competency in using the resuscitation trolley.
- On the unannounced inspection, we tested the HCRC emergency system and process with staff. We alarmed two emergency call bells in the clinical area. These bells alarmed very quietly in the maternity clinical area, main waiting area and at the main reception desk area. Once we had activated the call bells, we immediately walked to the reception where three reception staff informed us that they had not heard the emergency alarms, as the reception area was very busy and loud. The alert system was not situated at the reception desk but in a room behind it. We were joined by the building manager, who

told us that the building did not have an 'emergency call system' but a 'nurse call system' and it had been already reported to the landlords as needing updating but staff were unable to give us further details.

- Both the reception staff and estates manger informed us that the first person to respond to the activated alarm system was a porter, who would assess the emergency. If required, then an ambulance would be called for. We proceeded with staff to look for the emergency trolley, but staff were unsure exactly where it was kept. After asking one of the Urgent Care staff, we were told it was not stored on the main corridor for general access but in a clinical room. Unfortunately, we could not review it, as the clinical room was busy providing patient care. This did not assure us that patient safety and wellbeing in an emergency were being adequately managed. We raised this immediately with the HOM at the time of inspection. As good practice, guidelines state that the use of emergency resuscitation equipment and cardiac arrest procedures should be displayed and visible to all. (RCOG Safer childbirth 2007).
- We attended a consultant led obstetric clinic (Runcorn Clinic) at Halton hospital. This was a relatively old building, with dedicated maternity space of three clinical cubicles for two midwifery sessions per week, one clinical room, a staff office and two shared storerooms. Patients could access any of the three clinical cubicles, from a shared waiting area, through three separate doors. Staff had open access from the back, along a staff corridor.
- Each cubicle used curtains for staff access. At the time of our inspection, conversations and procedures could be heard easily between each cubicle and staff worried about maintaining privacy because of the curtains.
- We observed that there were no emergency call bells, oxygen or suction equipment in any of the three cubicles at the Runcorn clinic. This was highlighted to senior midwifery staff on duty at the time of our inspection.
- There was no resuscitation equipment or trolley dedicated to the maternity area at the Runcorn clinic. There was an emergency equipment store box, locked with a keypad, situated at the main Halton hospital reception. In an emergency, community midwifery staff would ring 2222, where the bleep holder and emergency team would bring the emergency equipment. Maternity staff did not check or use this equipment. Staff we spoke to were unaware what equipment was kept in the emergency store box. This did not assure us that risks to patients in an emergency were being adequately addressed.
- A risk assessment for Halton outpatients/Clinic C was completed April 2016 however; emergency systems and emergency equipment were not mentioned in the risk assessment report.
- Staff did have lone worker devices supplied to them but reported to us that they did not "have any faith in them" so they did not use them regularly. However, they did follow the lone workers policy. Staff told us that the trust were reviewing the lone worker devices but staff were unsure where this was up too. This risk review was overdue on the maternity risk register. There was no evidence of completed role specific risk assessments for lone workers.
- The maintenance department at Halton hospital maintained all the maternity equipment. We observed that some equipment had no maintenance stickers or had out of date portable appliance testing (PAT) stickers on them. In a storeroom at HCRC, three old unused broken blood pressure monitors were stored at the time of inspection. This meant that there was a potential risk to patients from equipment that was not appropriately maintained and monitored.
- A midwifery equipment asset register was kept by the trust. Equipment listed included baby and adult scales, Doppler machines to measure babies' heartbeats, thermometers and pulse oximeters. The register was missing data such as serial numbers, maintenance service level, responsible staff member, status, condition, risk, purchase date, warranty end date and date of last calibration.
- When asked, staff were unaware if the maternity facilities were audited and reviewed. RCOG (safer childbirth) 2007, recommend that facilities should be audited and reviewed at least every two years and plans made to rectify deficiencies within agreed timescales. The audit process should involve user groups and a user satisfaction survey.
- The clinical and office base at the HCRC was bright and spacious. There were facilities on the ground floor for patients and staff on the second floor, including an office base for the band 7 specialist midwives, the band 7 midwife co-ordinator and the Head of Midwifery.

Requires improvement

Are services safe?

- At HCRC, there were no "room in use" signs on the clinical doors but during the unannounced visit, staff assured us the signs were now being ordered but as the building did not belong to them, external permission to order and hang the signs was being sought.
- The clinical rooms for maternity use at HCRC, had staff swipe access. These rooms each had an examination couch, telephone, computer, printer and desk. They were well stocked with necessary equipment such as aprons, gloves, blood pressure machine, sonicaid to listen to babies' heartbeats and information leaflets.
- Each of the three clinical rooms, at HCRC, had a trolley on wheels that stored equipment for taking blood samples. These were clean and well stocked.
- There were male and female toilet facilities near the clinical rooms at HCRC and at the Runcorn clinic.
- Reception desks and waiting areas were situated in a shared space in the main reception areas. However, we saw no maternity patients waiting for long periods in the waiting areas.
- At the Runcorn clinic, there was a room available for the smoking cessation midwife and breast-feeding team when they visited intermittently, according to demand.
- A robust blood sampling collection system was in place in order for samples to be collected and taken to the appropriate trust laboratories for processing. However, the courier only collected samples from the Halton hospital clinic every Wednesday and Thursday at noon, therefore last appointment offered to patients was 11:40am.
- At the Runcorn clinic in Halton Hospital, there was a separate cubicle, away from the three maternity cubicles, used for patients who had received bad news.
- Every midwife had a sonicaid device (an electrical hand held machine to listen to baby's heartbeat to access wellbeing) and a pinnard (hand held device to listen to baby's heartbeat). However, staff informed us that they only used their pinnards when they had student midwife working with them. There were two cardiotocography (CTG) machines, one at HCRC and one at the Runcorn clinic.

Records

- Patient data was collected and stored by the use of a 'digital psystem. However, this was on the risk register as staff reported that effective, accurate and up-to-date information about patients were not always readily available and accessible. However, there were plans to implement a new template IT system in the future. Some staff said the pens were a "nightmare", others said they were "ok when they worked".
- The trust designed their own hand held notes, with input from some pregnant women. Staff told us the notes were updated eighteen months ago. There was no evidence of local arrangements or audit to monitor the notes to keep them updated.
- Within the booking pack information, there was an "internal windows blinds" leaflet from a private company. When staff were asked about the relevance of this, they assumed it came from higher management and were not sure that it was relevant to midwifery but they did not like to question it.

Cleanliness, infection control and hygiene

- Areas of the maternity service we visited were visibly clean and tidy.
- Staff completed online hand hygiene training, four times per year. Fellow staff members also assessed staff. However, during our inspection, we observed a staff member not washing their hands between patients, just changing their gloves.
- Staff and patients were seen using the wall mounted hand sanitiser dispensers, which were visible in every clinical area.
- We saw personal protective equipment for staff in the homebirth delivery packs. Aprons and gloves were also seen in all the clinical areas.
- An external agent directly collected all dirty clinical waste following a home birth from the patient's home. This prevented midwives from carrying dirty clinical waste in their cars.

Mandatory training

- Staff informed us that they attended a one-day bespoke community midwifery annual mandatory training day.
- In addition to the one-day community midwifery annual mandatory training, the midwifery service had an annual mandatory training session, which included record keeping, transfusion/venepuncture, mentorship and a screening update. 100% of staff had attended this training.
- The trust reported a 100% midwifery staff attendance rate for drills & skills incorporating cardiotocography (CTG) training update.

Requires improvement

Are services safe?

- The trust showed adult and neonatal resuscitation training attendance by midwives was 84.6% between May 2015 and April 2016.
- 100% of midwifery staff had completed safeguarding Level 3 training.
- One facilitator for midwifery training ran all the teaching sessions on the mandatory training day. The only guest facilitator were the neonatal team who ran the 1.5 hour neonatal resuscitation session.
- Senior staff informed us that two or three staff members were out of date for cardiopulmonary resuscitation (CPR) training due to the lack of trust trainers. At the time of our inspection, one senior member was about to attend the "train the trainer CPR session" in order to train the rest of her staff. CPR training included adult, child above 1 year old and child under 1 year old.
- Information provided by the trust showed that moving and handling training was completed by 61.54% of midwives and 84.62% of midwives had completed conflict resolution training over the last 12 months. There was no trust target provided.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training was completed as part of the trust mandatory eLearning package. The frequency of update for this training module was every 3 years. From 1 May 2013 to 30 April 2016, 88.46% of staff had completed the training. There was no evidence of a trust target for this training.
- One midwife informed us that suture training was provided on the annual skills and drill training but it was at the end of the day and it was optional. Most staff left before completing the training. Some staff told us that they attended a suturing workshop about three years ago and that this was one of the reasons for transferring a patient into hospital after a homebirth. This did not assure us that all staff were competent and appropriately trained in providing suturing to homebirth patients.
- Staff told us that water and pool birth training was provided "about three years ago". There was no training documentation provided by the trust. In addition to emergency drills and skills, training should include intermittent auscultation of fetal heart and water birth (RCOG, Safer Childbirth 2007). This did not assure us that all staff were competent and appropriately trained in providing a pool birth service to patients who request it.
- Staff did not complete any mandatory online eLearning CTG training packages. However, some SOMs had emailed staff the Royal College of Midwives (RCM) training package and encouraged staff to complete it. However, when asked, the SOMs did not keep a record of how many staff had actually completed this online training. Staff informed us that CTG interpretation was discussed at their annual skills and drills training.
- Staff informed us that Duty of Candour training was provided by the SOM on the annual mandatory training day however, this was no evidence of this on the training day agenda provided to us by the trust.
- All staff were sent an eLearning link to complete Female Genital Mutilation (FGM) training. Data from the trust reported that only 13 staff had completed the training. There was no evidence of a time recorded for this data or any trust target set.
- Prevent training (Prevent training focuses on all forms of terrorism and vulnerable individuals at risk of being groomed in to terrorist activity before any crimes are committed NHS England 2015) had a 61.5% compliance. There was no evidence of a specific time recorded for this data or any trust target set.

Assessing and responding to patient risk

- The maternity risk register has eight individual risks listed. Three were classified as moderate risk and five were classified as low risk. Review date was overdue in two of the risks. The HOM and risk management midwife reviewed the risk register. Staff told us that risk management meetings no longer took place but had been incorporated into the overall 6-weekly team meeting.
- One moderate risk listed involved the purchase and implementation of digital pens in November 2013, to collect patient data. Action plans included face-to-face meetings with the digital pens manufacturers, trust IT and staff to resolve data collection issues and the continual review of incidents forms completed as a result of these issues. At the time of the inspection, there were still ongoing problems with the digital pens.
- There were no clear policies or procedures for escalation of the deterioration patient. Staff told us that they were aware to ring an ambulance for transfer into hospital if required. However, when we reviewed transfer protocols and policies, there was no evidence of emergency pathways or procedures for staff to follow, stating only that staff should summon an ambulance to

transfer patients to an acute hospital. This did not assure us that staff were assessing and mitigating risks and that timely emergency care and treatment was provided to patients prior to the arrival of an ambulance.

- The maternity service did not audit ambulance response times. If a delay occurred, staff told us they would just complete an incident form.
- Some staff told us that the majority of patients they were caring for were low risk and emergency issues was not a concern for them. This did not assure us that staff considered the unexpected deterioration of a low risk patient or other persons in their presence.
- Staff informed us that a risk assessment for home birth was included in the home birth policy. However, there was no risk assessment template in the policy when we reviewed it. Staff informed us that if a patient came under the "amber" category (some concerns about having a home birth), the patient would be visited at home by the SOM to discuss the possibility of a homebirth in more details.
- Management informed us the root cause analysis (RCA), action plans and outcomes for the last three BBA (born before arrival) deliveries (eight in the last 12 months) had not been completed. We were informed that midwives were invited to discuss every home birth and BBA with the supervisor of midwives. Incident forms were completed with every BBA and reviewed by the risk management midwife.
- Staff informed us that patients who requested a home birth against professional advice would be seen by a SOM and might be reviewed by a consultant to review and discuss further. The trust informed us that there was no specific policy or guideline for patients who requested a method of care contrary to maternity guidelines and advice.
- There was a birthing pool risk assessment template attached to the Use in Water in Labour and delivery policy. Some staff were aware of this assessment tool and how it should be implemented.
- A screening incident assessment tool was available to staff, to collect sufficient information to determine severity of any screening incidents and how it should be managed. The trust, the regional Quality Assurance service and NHS England all contributed, completed and gave feedback to the service once it was completed. The screening midwife gave staff feedback on an individual basis.
- Staff informed us that they used a 'low risk' pathway to schedule visits for patients. This was the same pathway used for 'high risk' patients also; staff just added extra appointments according to individual patient needs. Staff said they used the pathways for patients pregnant with their first baby (primigravida) or patients pregnant with subsequent pregnancies (multigravida) not for low or high-risk patients. This did not assure us that individual care pathways were available or used correctly to ensure individual risks were assessed and individual care and treatment plans were implemented.
- The trust had agreed to take part in the national Grow Assessment Programme (GAP) programme to improve patient safety in maternity care (Perinatal Institute, 2012). This included using a customised baby growth chart software called GROW (Gestation Related Optimal Weight). However, when we reviewed six sets of patient records during the inspection, GROW charts were only completed in two of the sets of records.
- Maternity services risk management newsletters were issued twice a year. The trust provided us with two issues (December 2015 and June 2016) .These contained information such as the individualised growth charts information, a list of guidelines and leaflets that were updated, an intrapartum audit recommendations, trend analysis following incidents reports and a scanning reminder to staff.
- Venous thromboembolism(VTE) risk assessments were completed at the patients booking appointment. VTE is a condition where a blood clot forms in a vein. This assessment helps assess a patient's risk of developing a clot.

Midwifery staffing

- The community midwifery team consisted of a HOM, 25 midwives and one midwifery support worker. The Bridgewater community midwifery service offered care for patients living in the Halton area. Halton consists of a wide geographical area, including two towns, Runcorn and Widnes.
- There were 19 band 6 midwives, four band 7 specialist midwives, two band 7 team leaders and one band 3 midwifery support worker. There was administration and clerical staff across both midwifery sites. The band 7 specialist midwives included a part time midwife co-ordinator, a full time screening midwife, a full time risk management midwife and a young parent's midwife.

Requires improvement

Are services safe?

- The young parent midwife role was funded three days per week at band 7. The midwife was also funded two days per week as a band 6 clinical community midwife. However, her caseload extended to patients less than 19 years old, so all her time was dedicated to the young parent's role.
- Caseload numbers for full time staff were around 70 patients, this included antenatal, postnatal patients and newborn babies. Staff working four days per week had approximately 40-50 patients and staff working three days per week have a caseload around 30-40 patients. This complies with Birthrate Plus 2007, a national tool available for calculating midwifery staffing levels.
- There was a high sickness rate between December 2015 (16.6%) to January 2016 (10%). The trust sickness rate was 4.92%. Sickness rates remained a trust concern until April 2016, however, sickness rates had improved after this period, with only one member of staff off sick at time of inspection. During the high staff sickness period between December 2015 and April 2016, parent education classes and the homebirth service were suspended; therefore, patients were unable to access these services.
- A senior band 7 midwifery managerial post that was vacant due to sickness had been filled by a band 6 midwife, as a band 7 secondment opportunity, however, the band 6 post that remained was not back filled, and therefore the current staff member still had a small caseload as well as her managerial and supervision responsibilities.
- Agency and bank staff were not used to cover sickness absence. Midwives reported cancelling their own annual leave or were asked to work extra shifts to cover the shortfall.
- All midwifery staff vacancies were filled at the time of inspection. There was a regular attendance of student midwives in the community midwifery service. We spoke to two student midwives who had positive things to say about their placement, reporting they were well supported and had good learning opportunities.
- There were no medical staff employed directly by the Bridgewater maternity services. Three consultants from local trusts, lead three individual antenatal clinics in the community setting which Bridgewater community midwives supported. These clinics ran three times per week, Wednesday to Friday.
- The consultants followed their own local trust polices and guidelines. Staff informed us that they were happy for clinical decisions to be made by the consultant during the consultant led community clinics' using local trust polices and they would refer to the consultant for advice regarding clinical care.

Managing anticipated risks

- During our inspection, there was no evidence that the service assessed, monitored or mitigated risks relating to health, safety and welfare of their patients, such as emergency equipment at homebirths, risk assessments for environment and equipment, competencies of staff, benching or regular auditing of patient outcomes and services. This was discussed with management at the time of the inspection.
- However, during our unannounced visit, management informed us that the trust had responded promptly and took action to mitigate immediate risks around emergency equipment, staff training and competencies at a homebirth and the long-term plan and role of the SOM, as this was changing nationally. We were shown an action plan to review these areas, which provided assurance that the trust were responding to our feedback.

Major incident awareness and training (only include at service level if variation or specific concerns)

- Senior staff and management team reviewed the maternity services business continuity plan annually, reviewing the impact of major disruptions to the service due to loss of staff, loss of workspace, loss of IT, loss of equipment and/or loss of supplies.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as requires improvement because:

- There was no evidence around monitoring of services provided. There was no robust plan for auditing practices and procedures and there was no evidence that the service were participating in any local or national audits, apart from one small monthly audit of two sets of patient records per month.
- Midwifery skills, experience and competencies within the homebirth environment and potential emergency situations were not reviewed or monitored. Due to the infrequent homebirth rate, staff skills were often under-utilized for periods. However, there was no plan for staff to rotate into any of the local trusts to keep updated with skill aptitude and proficiency.
- There was no evidence to show that information collated on the maternity dashboard was used to inform or improve practice. Trust annual performance targets were not always sets on the dashboard. The trust did not routinely benchmark their service; therefore, there was no oversight of themes and trends.
- We found no evidence to confirm that there was a robust, continuous auditing process in place. Therefore, there was no oversight of themes and trends or practice improvement.
- The home birth rate was below 1% and there was no evidence to suggest there were plans to increase this rate.
- Water and birthing pool service were offered as part of the service but staff told us there had were no pool births over the last 12 months. There was no evidence to show that there was a plan to improve or increase the pool birth rate.
- All water pools belonging to the service were damaged at the time of our inspection and had not been replaced. Therefore, patients had to hire their own pools if they wanted to labour or deliver in water.
- The number of mother and baby readmissions within 30 days of discharge was not recorded on the trust maternity dashboard. Information provided by the trust showed between April 2015 and March 2016, there were 34 readmissions of mother or baby to an acute hospital. This represented about 2.1% of the patients cared for by the maternity service.
- There was no evidence of Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLs) information folders or visual prompts for patients with learning disabilities, in any of the areas we visited.

However:

- Every midwife had a named supervisor of midwives who provided support, guidance and supervision to other staff members. The SOMs and staff informed us that the SOM also maintained safe practice within the service to ensure protection for patients and their family. They met regularly with midwives to ensure a high standard of care was provided.
- The SOM completed annual staff appraisals. At the time of inspection, the completion rate was 100%.
- The Local Supervising Authority (LSA) annual audit took place on 30 November 2015. The service received positive feedback. However, the report recommended the midwifery team review their current audit process.
- We reviewed 10 of the 36 midwifery guidelines available on the trust intranet. These polices were in line with NICE guidance and were up to date. However, some of the guidelines were not easy to access on the trust computer as they were saved under various sub headings and titles. We addressed this at the time of the inspection with staff.
- Staff informed us that they did not have a specific antenatal care policy but followed the national NICE Antenatal care guidance as well as the local trust guidance, where the patient has chosen to book.
- We observed good multi-disciplinary working between midwives and with one of the trust consultants during a community clinic. Staff also gave us good examples of support provided by the safeguarding nurse team such as providing support for patient case conferences and help midwives prepare conference reports.

Requires improvement

Are services effective?

- There was patient access to a community midwifery service seven days per week and also by an out of hours on-call rota system. This meant that patients could access support 24 hours per day if they required it.

Detailed findings

Evidence-based care and treatment

- Senior staff informed us that there were no regular, continuous or best practice audits taking place. We saw no evidence of mechanisms in place to review the quality of care provided to patients or systems in place to highlight the need for improvements to the service.
- At the time of the inspection, only one regular audit was in place: a record keeping audit of two sets of patient's notes per month. Feedback from this audit was through supervision. Safer childbirth (2007) recommend that all birth settings should audit childbirth outcomes, evaluate clinical care, changes or trends.
- There was no evidence to show that the trust routinely benchmarked their service. We were informed that it was a "unique" service and there was nothing similar to benchmark with. NICE (2014) recommend that maternity services should provide a model of care that supports one to one care in labour for all patients and benchmark services to identify issues. This gave us no assurance that the service was assessing, monitoring and improving the quality and safety of the services provided.
- Some staff informed us, that they did benchmark against other local units and the Local Supervision Authority (LSA) but staff were unable to give us any examples.
- The trust was participating in the national Growth Assessment Protocol (GAP) This provides tools for assessment of fetal growth and birth weight through the Gestation Related Optimal Weight (GROW) software, including using customised antenatal growth charts for plotting fundal height and estimated fetal weight). Training was provided by local trusts. However, when we reviewed six sets of patient records during the inspection, GROW charts were only completed in two of the sets of records.
- A home birth audit took place between April 2013 and March 2014. This looked at geographical details, age range, weeks pregnant at booking, ethnic origin, number of previous babies born and reasons for cancelled home births. It also reviewed times of birth, baby weight, and methods of feeding. This was to be re-audited between 1-2 years but at the time of our inspection, there was no evidence of any re-audit.
- An internal midwifery service review audit was due for completion September 2015 however, results and action plans was not available from the trust when requested.
- Staff knew how to access policies and procedures and they were available in both written form and on the trust intranet. However, when we attended Halton hospital maternity clinic, staff could not access the trust intranet hub to review any policies. No paper copies were available. Staff informed us that if they needed any policy information they would ring another midwife at one of the office bases.
- Management informed us it was the role of all midwives to update the policies and guidelines. Team leaders and senior midwives discussed all policies and updates at a meeting known as the 'Task and Finish' group.
- Staff informed us that their guidelines and policies were based on NICE guidelines and there was maternity representation on the Bridgewater trust audit team.

Pain relief

- Entonox (a medical gas) was the main source of pain relief at home births. This is a mixture of oxygen and nitrous oxide gas, which a patient can breathe through a mask, or mouthpiece, which they hold and regulate themselves.
- Other methods of pain relief included using a Transcutaneous Electrical Nerve Stimulation (TENS) machine. TENS is a small, battery-operated device that has leads connected to sticky pads called electrodes. The electrical impulses help relieve pain and relax muscles. They may also stimulate the production of endorphins, which are the body's natural painkillers.
- A water and birthing pool service was offered to patients but there were no pool births reported over the last 12 months.
- Pethidine was not offered as a form of pain relief at home births. However, NICE (2007) state that pethidine, diamorphine or other opioids should be available in all birth settings. There was no risk assessment completed by the service.

Nutrition and hydration

Requires improvement

Are services effective?

- All midwives gave infant feeding advice antenatal and postnatally to patients.
- A breast-feeding team, separate to the main core community midwifery team, led the UNICEF UK Baby Friendly Initiative (BFI) Standards programme. The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and were supported in their chosen feeding method.
- There was some confusion between senior management and other members of the team as to whether the trust had received the full BFI award or was still working towards it. On the unannounced inspection, staff confirmed they had achieved BFI stage 2 award and were working towards the stage 3 award (the complete BFI award).
- Breastfeeding (BF) rates were recorded on the maternity dashboard with a target set of greater than 40%. Over a nine-month period between April 2015 and December 2015, BF rates were above 82% for seven months. The target from the National Infant Feeding Survey UK (2010) rate is 81%.
- The percentage of patient's breastfeeding at handover to the health visitor was also recorded. However, the varied and wide different between this rating and the breastfeeding rate were difficult to understand. Therefore, it was not possible to understand if the rates were declining, improving or meeting the trust's target.

Patient outcomes

- The maternity dashboard recorded monthly data from April 2015 to December 2015. Data recorded included patients booking before or after 13 weeks of pregnancy, percentage of planned and unplanned homebirths, breastfeeding and smoking rates and workforce data.
- It was unclear if the target column on the maternity dashboard was set against trust targets or national targets, as this was not clearly stated.
- Of the 24 items listed on the dashboard, only 11 had target figures set for them. Thirteen items listed had no data for the period or no target set or agreed. Therefore, there was no assurance that the dashboard served as a clinical performance and governance tool to help identify patient safety issues to ensure a woman-centred, high quality, safe maternity care.
- A separate maternity dashboard data collection template had completed information collected for April 2015 to March 2016. This template recorded monthly figures for the main maternity dashboard. Data was provided by the service and from the trust information department. This did not record target figures.
- The target set for patients booking by 12 weeks and 6 days was greater than 85%. From April 2015 to December 2015, this was achieved six of the nine months. NICE recommend that all women should be booked by the end of the first trimester (12 week and 6 days). July 2015 achieved 81.17%, September and October 2015 achieved 84%.
- From April to December 2015, the planned home birth rate was below 1%, there was no yearly trust target set for planned births at home. The national home birth rate was 2.3% (Office of National Statistics 2013). There was a 2.02% home birth rate recorded for April 2016. There was no evidence to suggest there were plans to increase this rate. Staff reported they had "tried everything".
- Between April and December 2015, there were four months that recorded unplanned home births. This ranged between 1.54% and 1.89%.
- Staff told us that two homebirths were cancelled due to low staffing level in December 2015. Patients delivered at their local hospital.
- During six months of a nine-month period, between April 2015 and December 2015, staff sickness levels were above the trust target of less than 4%.This ranged from 5.09% in July 2015 to 16.66% in December 2015. Staff informed us that parent education classes and homebirths had been cancelled for patients during periods of high staff sickness.
- Serious untoward incidents (SUI) were recorded as zero on the maternity dashboard from April to December 2015.
- Mother and baby readmissions within 30 days of discharge were not recorded on the maternity dashboard. Staff were not aware of the numbers or reasons for readmissions over the last 12 months .We were told, "there were not many" and they suggested the main reasons were poor weight gain by baby, baby jaundice and maternal bleeding after having her baby. Staff informed us that the risk management midwife, HOM and SOM, completed incident forms after all readmissions.

Requires improvement

Are services effective?

- Data received from the trust relating to mother and baby readmission data from April 2015 to March 2016, showed that there were five maternal readmissions, 28 neonatal readmissions and one unknown readmission. The reasons for the maternal readmissions included two patients readmitted for suturing of the premium, one for prolonged rupture of membranes (bag of water surrounding the baby in uterus), one readmission for infection and one readmission for raised blood pressure postnatally.
- There were nine baby readmissions for jaundice and twelve readmission for weight loss and being a poor feeder.
- The maternity dashboard recorded no pool births performed by staff in last 12 months. There was no evidence to suggest that this service was promoted or encouraged to patients by the staff.
- The Local Supervising Authority (LSA) annual audit took place on 30 November 2015. The service received positive feedback. Four domains and six midwives rules and standards (RCM 2012) were all achieved apart from one standard, which was partially met. The LSA recommended the midwifery team review their current audit process and undertake auditing of record keeping and standards of clinical practice. It was evident at the time of the LSA audit, that only one audit had been completed over the previous year.
- The LSA audit report also highlighted the need for supervision links within clinical governance. This was raised at the clinical governance meeting in March 2016, where senior management presented the LSA audit findings. The Chief Nurse sent the midwifery team a letter of congratulations following the report.

Competent staff

- As there was a low rate of homebirths and pool deliveries, there was no routine or mandatory trust rotation system in place to keep staff updated with skill aptitude and proficiency. If staff requested to rotate into a trust at their annual appraisal, then it would be arranged but there was no evidence if this had occurred. Some staff did not see this as an issue as they felt confident about their own skills and the support from the SOM's.
- Due to the low, infrequent homebirth rate, the trust did not record, document or audit staff skills between home birth deliveries. This did not provide assurance that management were aware of staff competencies, skills and experience to deliver care safety.
- We found no evidence that the service was aware of number of staff trained in suturing and the number of staff that had used their suturing skills in the past 12 months. Managers we spoke with confirmed that they had no overview of staff training or competency in relation to suturing.
- One midwife reported that she had undertaken four home deliveries in the past 12 months and stated that she had "attended suturing training years ago". She said she was honest when she spoke to patients who wanted to book a home delivery and told her patients, that at any time during the home delivery, if she did not feel confident, she would transfer the patient into hospital. She said that despite this, women were still happy to book for home deliveries.
- Similarity we found no evidence that there was water and pool delivery training or practice update provided to staff in last 12 months even though this was a service offered to patients. Managers we spoke with were unaware of staff skills for pool deliveries. We were therefore not assured that care and treatment was provided in a way that was safe to patients
- Another staff member told us she had performed one home birth within the last year but was not worried about maintaining her skills. NMC standards (2006) require midwives to be competent to support women to give birth normally in a variety of settings including in the home. To practise competently in caring for women who wish to receive midwifery care, regardless of setting, a midwife must possess the knowledge, skills and abilities for lawful, safe and effective practice without direct supervision. Therefore, we were not assured that the staff employed by the service received support, training and professional development that was necessary, to enable them to carry out their duties.
- Another midwife informed us that over the past two and a half years she had performed six home births, only one home birth since April 2016. She had never sutured. She also reported that she had received water birth training when she was a student midwife and since qualifying,

she had watched one water birth and had managed one water birth. However, another midwife told us she attended two home births in the last two months and felt her skills were up to date.

- Some staff did not think they would maintain all their skills when working in the community setting but felt that the community services was less stressful than working in an acute trust and looked forward to looking after "normal" patients. However, some staff reported their concerns to us about lack of emergency equipment at homebirths.
- There was no regular trust audit of skills and training (recommendation of the Joint Committee RCOG/ RCPCH, 1998). However, on the unannounced visit, management were undertaking a scoping exercise to obtain training and skill proficiency of staff.
- There was no dedicated trained frenotomy midwife; all cases had to be referred to other trusts. There were no plans for any midwife to undertake the training.
- There were no sonographer-trained midwives but staff told us that existing midwives had expressed interest in scan training however were told there was no money at present. They informed us that it had not been written into a business case yet but it was being discussed at finance level by the HOM. There was no evidence of this from the trust divisional meeting minutes provided.
- Funding for the smoking cessation midwife role was withdrawn in May 2016; therefore, the two day per week specific role was ending. Management informed us that all midwives were trained to provide some smoking cessation advice and they could refer patients to the Bridgewater trust smoking cessation service. However, when staff were asked about providing smoking cessation advice they were unsure when the smoking cessation midwife role was finishing and what the plan was moving forward. They were aware of the opt-in smoking cessation service and reported preforming carbon monoxide (CO) testing at booking. However, they were unable to tell us what the CO cut off level or criteria was for referral to the smoking cessation service.
- There was no specific domestic violence midwifery role. This was incorporated into the safeguarding nurse team.
- In the past 12 months, all community midwives had completed their annual appraisals.
- All staff were able to take blood from patients; however, the band 3 maternity support worker (MSW) was also trained in taking maternal blood as part of her role at the community antenatal clinics.
- Other roles of the MSW included breastfeeding support, home visits to weigh baby at ten days old, chaperone at clinics, follow up blood results, book scan appointments and test urine.
- A bank part phlebotomist (only role to take blood from patients) was also available at the Runcorn clinic on Wednesdays and Widnes clinic on Fridays.
- Staff told us approximately seven to eight midwives had completed the Newborn and Infant Physical Examination (NIPE) training. Currently one of these staff members was on long-term sickness. This offers parents of newborn babies the opportunity to have their child examined shortly after birth by a midwife.
- An orientation programme was provided for all new midwives. This consisted of a two-page list that staff and mentors signed when items on the list were completed. As similar format was available for student midwives.
- All community midwives were active mentors. A mentor is a mandatory requirement for pre-registration nursing and midwifery students (NMC, 2006a). Mentors are accountable to the NMC for their decision that students are fit for practice and that they have the necessary knowledge, skills and competence to take on the role of registered nurse or midwife.
- Team leaders worked one clinical day per week when possible, usually at a consultant clinic to maintain their clinical skills.
- There were four supervisors of midwives (SOM), including the HOM. This was a ratio of 1:9 (within RCM 2012 guidance), including two Health Visitors (HV). The main purpose of supervision is 'to protect the public by empowering midwives to practise safely and effectively' (NMC 2004).
- There was an on call rota for SOMs to ensure availability of a supervisor 24 hours a day, seven days per week by phone.
- All the SOM participated in the out of hour's on-call rota. SOM were on call about seven to eight times per month. However, staff informed us that the HOM did not undertake any clinical working hours.
- Some staff reported that the SOM worked very hard and felt well supported; however, other midwives told us some SOM were more supportive than others were and would come out to help out of hours while others were not willing to provide that level of support.
- SOM were allocated one day per month on the duty rota to complete supervision duties however, staff told us that this was not always possible due to clinical and

management duties. This was often not escalated to the management; therefore, SOM responsibilities were often incorporated into a normal working day or by completing roles in their own time.
- Staff were aware of the Nursing and Midwifery Council (NMC) revalidation requirements.Revalidation is the new process that all nurses and midwiveswill need to go through in order to renew their registration with the NMC.
- Trust information provided showed that between 2015 and 2016, 134 trust staff had accessed funded academic modules and workshops at levels 6, 7 and 8 at North West universities. Of these, only two midwives commenced a Level 6 module (Examination of the Newborn in May 2015).
- The trust reported that external funding for training during 2015 and 2016 was provided to 363 Nursing and Midwifery staff. Of these staff, CTG update training was commissioned, from an external provider, for 26 midwives, only two midwives had attended an external conference. Staff informed us that if they attended any external events they were usually free of charge.

Multi-disciplinary working and coordinated care pathways

Referral, transfer, discharge and transition

- Women could self refer themselves to the midwifery service or could be referred from other local services or from their GP.
- There was evidence of a good working partnership with the Family Nurse Partnership (FNP) for young parents (under 19 years) however, staff told us that at the time of our inspection, the FNP was at full capacity for referrals so were unable to take any more young parents. **The FNP is a voluntary home visiting programme for first time young mums, aged 19 years or under. A specially trained family nurse visits the young mum regularly; from the early stages ofpregnancy until their child are two.**
- Staff informed us that the midwifery service was developing a new multidisciplinary approach to providing parent education in partnership with the infant feeding team, FNP and Health Visitors.
- Staff reported a good working relationship with Children's Social Care services and the Halton Contact and Referral Team (CART) team.
- Some staff informed us that they worked closely with local schools and attended pastoral support meetings.
- Staff completed an "information sharing - Cause for Concern" form to keep staff within the team and outside agencies up to date. This was in addition to the completion of a compulsory safeguarding form.
- Staff told us that there was good communication and support between midwives and the three trust consultants and other local trust staff. Therefore, the responsibility of care and treatment for patients was shared to ensure that timely care planning took place.
- Consultants were happy to be emailed or phoned and midwives completed a hand written "show me" document, which was hand delivered or email to consultants to keep them updated on their patients.
- There was a regular student midwife attendance from Edge Hill and John Moores universities.
- The HCRC service provided scan facilities two days per week, which were staffed by sonographers from two local trusts. This relatively new service enabled patients to receive their scans locally, with a reduced waiting time but this was not yet audited by the service. There were no scan facilities at HRCR on other days of the week, so patients attended their acute hospital for a scan service.
- Staff told us that due to the high demand for scans, there were not always scan slots available for patients at HCRC when required and that the sonography staff were not always fully committed or understood the needs of the service. However, this service was only running since January 2016 and staff said it was still work in progress to improve the service and system.
- Staff also informed us that the HCRC scan facility was only for "Widnes" patients, Runcorn patients had to go to Halton hospital for their scan appointments.
- Staff told us that the service did have an infant feeding co-ordinator, who was a midwife but was not a direct member of the Bridgewater community midwifery team.
- Staff informed us that, when required, they referred patients to the physiotherapy department. There was no self-referral system for patients. There was approximately a 6-8 week waiting time for patients to be seen. Patients were seen in the hospital or clinics, no home visits were offered by the physiotherapy department.

Access to information

Requires improvement

Are services effective?

- Bridgewater trust purchased and implemented an IT system in November 2013, using electronic Digital Pens, to collect patient data. Since then, staff reported many problems with the system including experiencing missing data, which they had to find and re-enter onto the system. Staff said this affected the length of time allocated to each woman, which was affecting resources, clinic patient times and care. This was on the risk register and management were investigating a new system to improve data collection and data storage.
- Staff said they were concerned about the pens not collecting patient information effectively all the time but told us at the time of inspection that "touch wood, the staff had not missed anything yet". This did not assure us that equipment used by the service maintained secure, accurate or contemporaneous patient information at all times.
- The digital pen system did not interface with the trust 'systemOne' computer system therefore staff told us it was time consuming having to access two computer systems.
- Consultants did not have access to their own digital pens when working in the community clinics. We observed that one consultant had to borrow the midwives pens to complete their documentation.
- Information was shared between staff at small irregular team meeting, one to one meetings and by email. Staff informed us that regular formal team meetings were difficult to arrange due to staffing levels and clinical duties. Main team items were discussed at the six weekly joint team meeting. Items on the agenda included screening, risk management, staff appointments and service updates.
- Staff reported that communication was a challenge due to the wide geographical area they worked across and their busy workload. However, staff informed us that they usually met at the start and end of each working day to discuss daily workload, they were also happy to telephone each other, communicate through emails and arrange one to one meetings when required.
- One team reported that every Monday morning, their team met for approximately an hour to discuss weekly workload, home visits, off duty, feedback from incidents, home births and any major safeguarding alerts. These meetings were not documented formally.
- Team leaders reported that the monthly data collection for the maternity dashboard data template was very time consuming. They told us that they received no input or assistance from the administration staff. This involved collecting figures and data from the service and uploading onto a spreadsheet.
- At the time of a patients booking appointment, the community midwives completed a HV referral form. The HV would then plan to contact the midwives around 28-36 weeks of pregnancy to double check if the patient was still pregnant and would then arrange a home visit with the patient.
- Midwives informed us that they followed up and actioned all blood results. Abnormal results were faxed to GP or patients were referred to the assessment unit or labour ward, at their booked trust, for further investigations.
- During our unannounced visit, we spoke to the administration team who explained the system in place for recording all hospital discharge information in a register book. Midwives contacted the administration team at HCRC daily for patient discharge information. All discharge information was directed to the midwives office at weekends.
- Patient discharge information, from the community midwives service, was documented on a discharge summary sheet and scanned on to the trust IT SystemOne.
- Missed patient discharge information from hospitals to community midwives was rated as low risk on the risk register.
- Midwives completed a hand written discharge communication sheet after the baby was five days old, and posted it to the HV. Many HV were based at GP practices where community midwives held their clinics, so this was used as an opportunity to communicate face to face.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Staff informed us that all patients have a mental health assessment completed at booking and this was re-assessed during their pregnancy.
- Midwives were aware of how to referral patients to the specialist services.
- Postnatally, the community midwives informed us that they did not assess patients for mental wellbeing. This was the role of the HV.

Requires improvement

Are services effective?

- We were informed that MCA and DoLs training was completed by staff as an online e learning package.
- There was no evidence of MCA and/or DoLs information folder or visual prompts for patients with learning disabilities.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated caring as good because:

- Patients and relatives were complimentary about staff and the care they had received.
- Staff scored well in the friends and family test.
- Staff were flexible in providing care across a wide geographical area.
- Staff were often requested by families to provide care in subsequent pregnancies.
- Patients had time to discuss concerns with staff during clinic appointment times.
- A part time drug and alcohol specialist midwife was available to patients.

There was no dedicated staff member on the community midwifery team who specialised in supporting bereaved parents and families.

Detailed findings

Compassionate care

- The Friends and Family Test (FFT) showed between January and March 2016, 16 patients completed the antenatal responses. 100% reported they would recommend the service. There were 63 postnatal responses; between 95% and 100% reported, they would recommend the service. Bridgewater trust had set a threshold of 95%, therefore achieving this target.
- Staff told us that they gave good care, and that families often specifically requested them, to provide care, for subsequent pregnancies. Patients, we spoke too, were very happy and satisfied with the information and care they had received from the midwives, who treated them with dignity and respect.
- We observed a consultant led community clinic and several antenatal appointments, we observed midwives and doctors speak to patients in a calm, caring and professional manner.
- Staff informed us that if they were aware of any sensitive personal issues or maternity problems, patients would be directed into the maternity clinical areas immediately and remain there until ready for home or transfer to hospital. This assured us that staff treated patients with dignity and respect in a caring and compassionate manner.

Understanding and involvement of patients and those close to them

- Patients were given choices such as having a homebirth, a pool birth, skin-to-skin contact between mothers and their baby to increase bonding and different methods of feeding such as breast or bottle-feeding.
- Staff told us they involved partners in care, if partners wished to do so. This included attending parent education classes, being present and having an active role at a homebirth and being included in the care of the newborn baby.
- Staff proactively encouraged patients and others to provide feedback via the friends and family test surveys.
- Written information, to aid parenting skills, was provided for patients and their families at different stages of their pregnancy and once baby was born. This included safety information about correct sleeping positions for baby as well as general care of the newborn.

Emotional support

- We observed staff discussing emotional wellbeing directly with patients in a sensitive and dignified manner. We also observed clinical staff discussing sensitive information with respect and professionalism.
- We observed that patients were allocated enough time during their clinic appointments to discuss issues with midwives in a timely manner.
- A part time drug and alcohol specialist midwife was available to patients. At the time of our inspection, there were two patients on her caseload. This role also included providing support and information to the midwifery team and working closely with local drug support agencies.
- There was no dedicated staff member on the community midwifery team who specialised in supporting bereaved parents and families.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated responsive as good because:

- Midwives facilitated clinics across a wide geographical area, close to patient's homes.
- Midwives provided weekend drop in clinics for patients. This enabled patients to receive care over a weekend without a booked appointment.
- The young parents midwife cared for young parents under 19 years old.
- There were new scan facilities for patients at HCRC, two days per week. This was a new service offered and reduced the need for patients to attend their local trust scan department. This reduced the amount of patients that had to travel to the local hospitals for scans.
- Parent craft classes were provided during the day and evenings in Runcorn and Widnes, for patients and their partners.
- A language interpreter service was available to staff and patients by a phone system and leaflet in different languages were available for download.
- An "Early Bird" teaching session was offered to newly pregnant women, which discussed topics that would normally be discussed during an antenatal booking.
- Staff informed us that the two team leaders allocated all new patient referrals to staff within the team. We were informed that the reason for this was to act as a triage and signpost patients correctly, depending on their individual needs. This system offered patients booking appointments as early as possible in their pregnancy. Therefore, offering more flexible to the patients.

However:

- There was no evidence to show us that specific processes or pathways were available for patients with individual needs such as learning difficulties or dementia or complex needs.
- Trust birthing pools were damaged and had not been replaced, therefore patients had to hire their own pool if they wanted to labour or deliver in water.

Detailed findings

Planning and delivering services which meet people's needs

- The community midwives worked in clinics across a wide geographical area. This provided most patients with antenatal care close to their home.
- Staff informed us that the two team leaders allocated all new patient referrals to staff within the team. We were informed that the reason for this was to act as a triage and signpost patients correctly, depending on their individual needs. This system offered patients booking appointments as early as possible in their pregnancy. Therefore, offering more flexible to the patients.
- There was a young parent's midwife who offered one to one support to young patients less than 19 years. She worked closely with the safeguarding team and the local Family Nurse Partnership.
- Education sessions for expectant parents were flexible to encourage and enable parents with other responsibilities to attend. Both day and evening parent craft sessions were held between two locations on a rotating basis.
- Parent craft classes were offered twice a month in Runcorn, 5:30pm-6:30pm. Parent craft classes were offered four times per month at Widnes, 6:30pm-7:30pm. Patients were advised by staff to refer to NHS choices website for topics such as birth plans.
- Two hundred and thirty nine patients attended parent craft classes in Widnes over the last 12 months however; parent craft was suspended from December 2015 until April 2016 due to the high sickness levels. Numbers of partners or other family members who attended these sessions were not recorded.
- 65 patients attended parent craft classes in Runcorn over the last 12 months however, parent craft classes were also suspended from December 2015 until April 2016 due to the high sickness levels.
- For both sessions in Widnes and Runcorn, the agenda items included labour, pain relief, postnatal care and infant feeding.
- Every patient had a named midwife who was responsible for ensuring she had personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period.
- Staff and patients, we spoke to, reported that continuity of care from staff was provided, enabling a positive experience for the patients.

Good

Are services responsive to people's needs?

- We attended a daytime "early bird" parent craft session, which was approximately an hour long, during our inspection. This briefly discussed topics that would normally be discussed during an antenatal booking appointment such as choice of where to book and deliver your baby, screening blood tests, food to avoid eating in pregnancy and common ailments in pregnancy. Attendees were then signposted to the NHS Choices website for topics such as smoking, folic acid, exercise, supervision. Six newly expectant mothers attended. From our observation during the session, home births were not discussed or promoted comprehensively by staff. Free multivitamins were given out to those who attended. This session was also provided in the evening between 6pm-7pm.
- Community midwives offered an average of three postnatal appointments. First visit following delivery, when baby was five days old and ten days old.
- There was no Maternity Service Liaison Committee (MSLC) or equivalent to design services to meet the needs of the patients.
- There were new scan facilities for maternity patients at HCRC, two days per week. This service reduced the need for patients to attend their local trust scan department. However, staff told us that there were some problems with the availability of hospital sonographers. In these cases, patients would have to travel to their local hospital for their scan appointment. There were no midwives trained to scan patients.

Meeting the needs of people in vulnerable circumstances

- Community midwives reported that they did not have any patients with complex social factor needs such as asylum seekers or domestic abuse patients as part of their caseload at present. There was no specific team or staff member to provide support to these patients.
- There was no specific perinatal mental health midwife or bereavement midwife. Staff informed us they provided care and support with the assistance of other services such as the trust safeguarding team.
- The number of antenatal visits a patient would receive was dependant on their individual needs and circumstances. There would be an increased number if there were concerns for their health and wellbeing either physically or emotionally.
- All antenatal patients and postnatal breast-feeding patients received free multivitamins.
- Translator services, to assist during talks given to patients about care, were booked through the administration team at HCRC and staff told us that it was used more at Widnes services than Runcorn services. Staff informed us that they downloaded leaflets from the internet in different languages when needed.
- Young Parents (below 19 years old) were offered a home visit around 36 weeks of pregnancy to discuss any child protection issues, labour, pain relief, why and how to contact their hospital and baby movements. Partners of the young parents were invited to attend also. The trust did not offer any specific parent craft classes or groups for young parents.
- Over three different weekdays, there were three dedicated clinic times for young parents to attend. Out of hours and weekends, young parents were advised to contact their local trust.
- A part time drug and alcohol specialist midwife was available to patients. At the time of our inspection, there were two patients on her caseload.

Access to the right care at the right time

- Community midwives were on call, out of hours, about 3-4 times per month. Staff informed us this provided appropriate cover for their patients and services.
- Staff told us that there are two midwives on call for planned home births. However, if there was no home birth due, there was only one midwife on call. Some staff raised concerns about the large geographical area that needed covering when there was only one midwife on call.
- There was a third midwife also on duty to facilitate a maternity drop-in clinic, which ran on a Saturday, including bank holiday weekends.
- If midwives were required out of hours, the on call midwives would be alerted and contacted directly by the ambulance service, who kept an on call maternity staff list. Patients did not contact the out of hour's midwives directly.
- There was evidence of a buddy system between midwives, enabling adequate service cover during times of absence, annual leave and busy clinical periods. This ensured good continuity of care. However, staff told us that sometimes staff felt uncomfortable about covering staff on the opposite team, as they may not feel familiar with the geographical area.

Good

Are services responsive to people's needs?

- We observed patients being seen quickly by their midwives, when they arrived for their appointments. There was no evidence of any extended waiting times.
- Staff reported that they were flexible, between pre-arranged clinics, to review patients as near as possible to their homes or offer homes visits whenever possible.
- The capacity for maternity scans for patients was being increased by the new scan facility at HCRC. This was available to some patients, depending on their geographical location, two days per week since January 2016. Patients attended their local acute trust for scan facilities for the remainder of the week, out of hours and at weekends.
- Staff informed us that around seven to eight midwives had completed the Newborn and Infant Physical Examination (NIPE) training. This offeredparents of newborn babies the opportunity to have their child examined shortly after birth by a midwife.
- Staff reported that they had good working relationships with the local trusts that their patients were booked at. Midwives informed us that they did not have any difficulties or delays referring patients into the local trusts for further midwifery or consultant review, tests or scans.

Learning from complaints and concerns

- Between April 2015 and March 2016, there were 88 formal complaints recorded in the Bridgewater trust annual report. However, this was not broken down into individual services. There were 198 informal complaints and/or concerns raised for this period for the Halton area but again this was not broken down into individual services such as midwifery. The report included examples of service improvement and lessons learnt but this did not mention or include the maternity services.
- Information provided by the trust reported three complaints for the midwifery service over the last 12 months (no specific date stated). From April to December 2015, the maternity dashboard recorded complaints in only two of the nine months, 0.86% in August 2015 and 0.94% in November 2015. The annual maternity target was less than 1%.
- Staff provided us with one example of a change in practice following a complaint about a baby's growth and a placental abruption. They told us that some paperwork had been changed since this complaint occurred in order to mitigate the risk of this type of incident and complaint occurring again.
- Lack of patient care, complaints and issues around miscommunication were classified as low risk on the maternity risk register. Staff informed us that these were mainly associated with recent high staff sickness levels, which had improved at the time of our inspection. Staff told us that it was the role of the SOM, through supervisory annual reviews, training and updating to help mitigate these risks.
- We observed an example of a patient complaint, which was dealt with in a timely manner.
- Staff told us that lessons learnt following complaints were shared with staff at the six weekly team meetings. However, staff were unable to tell us of specific changes in practice following lessons learnt from complaints.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well led as requires improvement because:

- Some staff were unclear about the vision for this service and what plans there were for the service in the future.
- There was no evidence of a strategy or plan for continuous improvement or sustaining the service.
- There was no evidence of clear systems and processes in place for mitigating or managing risks and performance of the service.
- There were no examples of engagement or forum groups that staff could attend. There was no evidence provided or examples from staff demonstrating that they could present ideas, discuss and develop opportunities or influence changes within the maternity service.
- Some public engagement had occurred but there was no specific trust Maternity Services Liaison Committee (MSLC). The MSLC is a forum for maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families.
- The midwifery service did not take part in the Speak out Safely (SOS) campaign. This campaign aims to encourage NHS organisations and independent healthcare providers to develop cultures that are honest and transparent, to actively encourage staff to raise the alarm when they see poor practice, and to protect them when they do so.
- There was no clear management strategy or plan to increase the planned homebirth rate.
- Staff informed us that there were some financial concerns for the future of the service among staff. Staff told us that many staff requests or service requirements were constricted by the reduced availability of finance to the service and this was often the focus point for discussion at team meetings.
- The majority of staff were well supported and midwives were enthusiastic to be part of the Bridgewater midwifery service. However, some staff felt there was a divide within their midwifery team especially between band 6 midwives and other senior team members, which could affect staff relationships and morale.

However:

- During our unannounced visit, management had responded well to some risks, which had been identified and escalated during our announced visit. This included an action plan to review staff competencies, skills and training and undertake a staff competency assessment framework, review emergency equipment at homebirths, add new topic areas to the maternity dashboard for monitoring process and complete an clinical audit for all homebirths.
- A member of staff was awarded “Mentor of the Year” from a local university. The midwife had been nominated by a student midwife for all her hard work and support she provided.
- Most staff felt they worked in a “unique” service. Reasons for this included that they were the only community based midwifery service in the country, they attempted at all times to provide continuity of care, patients knew who they were, staff were flexible and they provided more personalised care.
- Band 7 midwives told us they had good support from their manager, who was visible and had an open door policy to discuss issues.
- The HOM was involved with national midwifery groups and the Royal College of Midwives. Dissemination from these meetings were shared with midwifery staff by the HOM at the six weekly team meetings.

Detailed findings

Service vision and strategy

- Management told us about being involved in the local NHS vanguard partnership to review new care model programmes and supporting improvement of the service. However, midwifery staff we spoke to within the teams were unclear about plans for the future of the service and were not familiar with the wider trust strategy or vision. When we reviewed the Halton

operational and strategic plan 2016/17 to 2020/21 provided by the trust, there was no evidence of a specific vision or strategy for the community midwifery service within this document and no evidence to maintain or improve the sustainability of the service.

- There was no clear strategy or plan to increase the planned homebirth rate. Management and staff told us, they had tried everything to improve the homebirth rate but it was low all over the country so felt they had tried everything. From April to December 2015, the planned homebirth rate was below 1%, with no yearly trust target set for planned births at home. The national home birth rate was 2.3% (Office of NationalStatistics 2013).

Governance, risk management and quality measurement

- Risk management was assessed and monitored by the HOM and risk management midwife, with support from the SOMs. There was no evidence to assure us that systems and processes were in place to improve and evaluate quality of care in order to improve practice and sustainability of the service.
- There was no evidence of a clear governance structure. There was no evidence that risk was managed within a framework that included clinical audits, education and training, complaints, health and safety, service user involvement and service development.
- There was no robust evidence to show us that there were links within the Bridgewater trust wide strategies and initiatives and that risk management was integrated within the general trust management and business plan.
- The trust provided us with the Quality and Safety Committee meeting minutes from March, April and May 2016. There was only maternity representation at the April meeting. At this meeting, a presentation was given about the Midwifery Service, detailing background, performance monitoring, staffing, external review of screening and supervision, financial sustainability, development and future plans. Members of the Committee were invited to spend time with the Midwifery Services. This had not occurred by the time of our inspection.
- The trust also provided us with the Clinical Governance meeting minutes from March and May 2016. There was only midwifery representation at the March meeting, where senior staff presented the LSA report. Staff told us that they only attended these meeting if they were invited.
- A midwifery service away day (half day) took place in December 2015. Items on the agenda included revalidation, intrapartum audit feedback, LSA audit visit, future of supervision and service update.

Leadership of this service

- Band 7 midwives told us they had good support from their manager, who was visible and had an open door policy to discuss issues.
- Some band 6 midwives said that “some management staff were more approachable than others and some could be firm, intimidating and formidable” and that this would affect what staff discussed with managers.
- Some band 6 midwives told us that management “took care of issues” while they got on with their day-to-day work.
- Senior staff reported that the HOM treated all senior staff fairly but they “didn’t bother her with day to day stuff” and tended to resolve problems or issues among themselves.
- There were examples of good team leadership where staff felt supported. Examples included fairness among staff shifts in the duty rota, on call support and supervision support for homebirths.
- Some senior staff were unaware who they or other members of the team were accountable too within the trust executive board team. Not all staff knew exactly who had responsibility for whom within some senior midwifery roles. Some staff were unsure of the role of some band 7 midwives and informed us an incorrect title and role for one of the senior team.
- Senior management staff reported that they would feel comfortable contacting and approaching senior trust management and the executive board but we were informed that they had no reason to do so and could not give any examples of when they did seek trust support.
- There were no formal arrangements in place between the maternity management and trust senior executive team for regular one to one meetings. Staff informed us that there had been many executive team changes and “they needed time to settle before a formal plan was arranged”.

Requires improvement

Are services well-led?

- Senior staff said they did feel they had a "voice" within the executive team if needed. However, no examples were given. This gave no assurance that a robust, active communication network was established between both teams.
- The trust informed us that there were leadership and management training programmes available to senior staff. However, when we asked senior midwives about this, they were not aware of any such training. This gave no assurance that a robust, active communication network was established between both teams and that staff professional development and evidence based practice was not discussed effectively.
- Midwives reported having a good working relationship between themselves and they did feel supported by each other and their teams. However, some staff reported a divide between the band 6 staff and some of the band 7 staff, which they said could affect open and honest communication and staff trust.
- Some staff told us that there was little difference between some band 6 and band 7 roles but were "grateful" for their role therefore did not raise it with management.
- Senior staff felt they had a "voice", and felt valued and respected. One senior member told us they felt more part of the trust since it became the Bridgewater Trust and that the Chief Executive Officer (CEO) was making a difference but staff were unable to give us any specific examples.
- One member of staff informed us that some roles were not well supported by other staff members due to a lack of appreciation and understanding of specialist roles and responsibilities. They told us that management were aware of this but nothing had been done to improve the issue.
- A staff member said the community midwifery service needed to move into the "21st Century" and there was no strategy or vision for the future.
- Some staff said management had lost direction and had no drive or enthusiasm any more. Staff did query the level of support senior management received from the executive board and all levels of staff informed us that they felt that the midwifery service was not high on the board's agenda. The HOM was involved with national midwifery groups and the Royal College of Midwives. Dissemination from these meetings were shared with midwifery staff by the HOM. This gave us assurance that shared best practice and national issues were discussed within the team.

Culture within this service

- Staff said that the service did not take part in the national Speak out Safely (SOS) campaign even though the Bridgewater Trust endorsed this. The SOS campaign encourages NHS organisations and independent healthcare providers to develop cultures that are honest and transparent, while actively encouraging and protecting staff who raise the alarm when they see and report poor practice. This did not assure us that staff were supported to raise concerns about wrongdoing or poor practice and that they felt confident that their concerns were addressed in a constructive way by the trust.
- Some staff said members of the management team were accusatory and had a negative attitude when approached by staff. They said that there was a first response culture from management of saying "no" first but management would often reconsider their reply later.
- Staff said that a lot of team information and management feedback was often left for discussion at the six weekly team meeting. Examples of standard items on the team meeting agenda included guest speakers, service update from the HOM, screening and risk management. However, some midwives reported that these meetings were often driven by a push for financial savings and not as productive as they would like them to be.
- Some staff reported there was good team working but the band 6 staff stuck together, supported each other and socialised together. They reported that some band 7 midwives were a tight group and some senior staff had a close link with management, which could affect the working relationship within the teams. This did not assure us that there was always an open and transparent culture among all the staff.
- Some newer staff to the team said they felt well supported, were part of a friendly team and were given adequate time to be supernumerary and complete preceptorship programmes.
- Midwives that we spoke to, felt they had not witnessed any harassment or bullying within the teams and reported, "it would not be allowed" by management.

Requires improvement

Are services well-led?

- One midwife told us that she felt the community midwifery service felt part of the trust and the service put the family at the centre of its care.

Public engagement

- Staff informed us that 18 months ago, some patients were involved in the design of the maternity hand held notes and large pull up posters. These posters were displayed in the waiting areas.
- Bridgewater Community Healthcare trust took part in a Patient Partners Scheme, encouraging service users to input their experience to help the trust makes changes for the better. In the maternity service, it also enabled patients to say thank you and forward positive comments to midwifery staff. Patient Partners were invited to the LSA annual audit visit to the trust and contribute to the Cheshire and Warrington Liaison Committee. However, staff were unable to tell us how many service users were currently involved with the Patient Partner scheme.

Staff engagement

- 241 staff at Bridgewater Community Trust took part in the 2015 National Staff Survey. The total response rate of 28% which was below the average for other community trusts in England. The response rate was also lower than the response rate in the 2014 survey (38%). However, only three community midwives returned their questionnaires in 2015, which was a total 1% of the overall response rate.
- There were no examples of engagement or forum groups that staff could attend. There was no evidence provided or examples from staff demonstrating that they could present ideas, discuss and develop opportunities or influence changes within the maternity service.

Innovation, improvement and sustainability

- A member of staff was awarded "Mentor of the Year" from a local university. The midwife had been nominated by a student midwife for all her hard work and support she provided.
- Most staff felt they worked in a "unique" service. Reasons for this included that they were the only community based midwifery service in the country, they attempted at all times to provide continuity of care, patients knew who they were, staff were flexible and they provided more personalised care.
- When staff were asked if they had been nominated, been entered or won any trust, regional or national achievement awards recently, we were informed "we wouldn't nominate ourselves" and had not been put forward by the trust management for any awards.
- The trust had received a reduced income from the CCG for the midwifery service in Halton. This was on the risk register as a moderate risk and actions to reduce the risk were under review.
- Management were reviewing and monitoring monthly costs applied by acute providers, monthly data collected for maternity dashboard outlining activity and full details of price and coding requested from acute providers to monitor financial balance.
- Annual data collection from April 2015 to March 2016 recorded number of bookings into the service as 1565 patients. Number of home births for the same period was 11 patients. There was no evidence to improve or increase the home birth rate which was below 1% (Office of National Statistics national average was 2.3%, 2013).
- The homebirth rate was classified as low risk on the risk register, which was last reviewed in June 2015. We were informed of a initiative by staff in 2014 to encourage low risk pregnant patients to consider being assessed at home when labour commenced with the view of continuing care and delivery at home. Only one woman agreed to take part. There was no evidience of another initiative since then.
- Management told us that the trust was involved in the regional Vanguard new care model programme. (NHS initiative towards delivering and supporting improvement and integration of services). This involved looking at new models of care and a further community hub vision of providing maternity care. However, there was no evidence at the time of our inspection, how this would affect or change the existing maternity community service.
- The SOM informed us that they had contributed to the North West SOM group about the possible national changing role of the SOM and the effects this could potentially have on a service provider. At the time of inspection, the community midwifery services were waiting LSA feedback and national guidance to be

Requires improvement

Are services well-led?

published; however, there was no local strategy plan for the changing role of the SOM within the service. We observed and staff told us that the role of the SOM within the maternity service was vital and an intrinsic part of the work provided, therefore was no assurance that appropriate action was being taken by the trust to support this possible role change.

- Midwifery management had attended the first finance and performance group meeting for Bridgewater trust to discuss finance and budget issues, training, sickness and had dates in the diary for the year-end.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 1 c e** • The provider must ensure staff have the necessary competences, knowledge, skills and experience to deliver care and treatment safely during a homebirth. • The provider must ensure all staff are trained to use all emergency equipment they may need to use

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 1 a b** • The provider must ensure systems are in place to assess, monitor and mitigate risks relating to the health, safelty and welfare of service users.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.